Encounter Data to 837 Format
Frequently Asked Questions (FAQs)

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CUP	This change is going to cost the plans hundreds of thousands of dollars in programming, software and staff resources. We are estimating 50K at a minimum maybe more. Encounter data reporting is not mandated by HIPAA – Why even make the change? We would really like a better explanation on the why – is it being mandated by CMS or other regulatory agency?	MAA made the business decision to adopt the 837 format to process encounter data from the plans for many reasons such as: 1. To facilitate data transfer and data processing in a standard format. 2. The standard format supports the comparison of fee-for-service and managed care experience. 3. Provides a common format with the flexibility to change or add standard data elements as needs change. 4. Other states are successfully collecting encounter data in the standard format. 5. Quality of care monitoring and Quality of Care studies will benefit from the use of a standard format across states. 6. CMS requires states to use encounter data in their rate development and risk adjustments.
CUP	What is the proposed time line for the transition to this format?	Plans will continue to report in the current proprietary format and time schedule for all services processed on or before June 30, 2004. Services/claims processed on or after July 1, 2004 will be reported in the X12N format, with the first report due in January 2005.
CUP	What is the expectation for providing pharmacy data? Will we be able to continue to provide it separately from our submissions as we currently do?	MAA will expect the plans to continue to submit pharmacy data in the current proprietary format until the standard NCPDP 1.1. batch report format is implemented.

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CUP	Will MAA EDU or ACS be certifying the TCS? (Transaction Code Set)	ACS accepts transactions that pass through EDIFACS. This process does not edit the transaction for "content".
CUP	Will record errors create an error for that record only, or will the entire file be rejected? Who will make the decision? MAA or ACS?	ACS EDI Gateway will be receiving the transaction and directing it to the MMIS Encounter Data Program for processing. After processing, ACS, based on MAA criteria, will send rejected records to the plans for action. Entire files will only be rejected if they do not pass EDI Gateway formatting.
CUP	Loop 2010AA Segment REF01 lists "1D" for the qualifier. Will you only accept the Medicaid number here? The standard lists several other qualifying identifiers that can be used i.e. EI=Employer's Identification Number which could be the TIN?	Yes - For MAA this must be 1D followed by the provider's Medicaid ID number until such time that the National Provider ID number is implemented. MAA will "flag" records when the Medicaid ID does not match the Master Provider File but will not reject records if the Medicaid ID does not match the provider type. The qualifier "EI" does not represent the provider's tax ID number in this case. "EI" represents the identification number used by the payer specific to the employer. Again, for MAA the primary identifier is the provider's Medicaid ID number.
CUP	Please define "Subscriber" CUP defines each member as a single "subscriber" for this line of business.	MAA defines each client as the subscriber and the subscriber is also always the patient.
CUP	Loop 2300 Segment DTP01 – CUP does not store the time for ambulance transport. Also if this edit is based on Place of Service, how will the plan/MAA address the professional fees during trauma team ambulance transport?	This segment is situational and will not be edited for content. If MAA were to pay the claim (these encounters are not edited by MAA claim processing system) the correct Standard Place of Service Codes in the 837P for professional services rendered during the transport are:

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		41 = Ambulance land or 42 = Ambulance air/water.
CUP	Loop 2300 Segments CR1 and CR2 Ambulance Transport and Spinal Manipulation service information. Your companion guide does not indicate what fields are to be reported. CUP does not store or require this information currently.	MAA does not require these fields for encounter data information. If you are reporting Ambulance Transport or Spinal Manipulation claim/encounter information then please make sure these segments follow the Implementation Guide and "gap-fill" the information. This information is not edited for content.
CUP	Loop 2300 CRC03 EPSDT data is not sent to us in this fashion under current contracts. How do we report this?	This information replaces the current proprietary format using YR/NR. At this time MAA does not edit this information in encounter data. Follow the codes listed in the addenda to the IG and "gap-fill' the information. MAA will not edit this for content.
CUP	What formats will MAA use to return edits to the plans? An 835? Proprietary?	MAA will use a proprietary format to report errors. The Encounter Results Transaction (ERT) report will be generated from the edits in MAA's Encounter Data Program process. Corrected encounter records maybe resubmitted in the next transmission.
CUP	Loop 2400 Segment LIN – The guide indicates required if the drug is dispensed at provider's office. MAA requires only if billing for J-code. What about temp codes?	MAA has deleted the requirement for plans to report NDC codes in the 837 X12N transaction. The NDC numbers are still required when reporting retail pharmacy information in the proprietary format. Temp codes are reviewed and if adopted by MAA, updated in MMIS effective January 1 of each year.

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CHPW	Please explain the process that the file will need to be submitted. Per an earlier all plan meeting, my understanding was that this file would bypass ACS as it is not going to go through MMIS. Is this correct? Or will it go through ACS and not MMIS? Or have you decided to have it go through MMIS? I'm asking this because I'm trying to understand the possible rejection of the file from ACS upon receipt if there are standard 837 fields missing in the file (I know you mentioned "... the HIPAA rules for required and situational data need not be met').	The 837s will be transmitted to ACS-EDI Gateway and must meet proper/required formatting of the transaction. ACS uses EDIFACS to certify formatting. The content of the transaction is not edited here. Once the submission is received ACS will run the transactions through an Encounter Data Program (similar to what they do now). Here the data will be edited for content validity such as (diagnosis and procedure codes and client/provider master files). ACS will send an Encounter Record Transaction (ERT) report to the plans.
CHPW	How will the error rates be calculated to derive the 2% error rate threshold? We noted several that were "required if known". How will this be enforced?	1. The ACS EDI-Gateway reviews data for formatting errors. This includes missing data, or incorrect 8-fills, 9-fills, 0-fills, or hyphen-fills for required fields. Please see the ASC X12N 837 Companion Guide for more detailed description of the EDI edits applied. MAA expects that certain fields at this level must be "gap" filled to pass the edits. 2. Quarterly analyses will be completed by EDU. An EDU analysis/evaluation may result in a request that certain encounters submitted during a time period, including an entire quarter, be resubmitted, depending on the extent and severity of the problem. EDU will coordinate closely with Division of Program Support/Healthy Options Contract Managers to finalize analyses and with Plan technical representatives to correct identified errors. 3. The actual error rate will be addressed in the

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		HO contract and final instructions to plans.
CHPW	If a file needs to be resubmitted because of error rate not being met the first time, are you expecting only 'corrected' data to be submitted? Versus a complete file?	MAA will expect the plans to correct only data that was *rejected* on the ERT.
CHPW	How will Rx data need to be submitted? ADDITIONAL QUESTIONS Received 05/05/04: How will MA handle errors in the Pharmacy data? Will it be incorporated into the new error process including the assigning of an ICN and the submission of only corrected records with the ICN, or will it follow the existing process with the existing format and require full submissions? What will be the error thresholds on the pharmacy data alone if subjected to the old process rules? If a new format with ICN will be incorporated, where will the ICN be incorporated into the current file? Will the Provider Crosswalk be required for the pharmacy data submissions?	MAA will expect the plans to continue to submit pharmacy data in the proprietary format until the standard NCPDP batch report format is implemented. Until the NCPCP 1.1 batch report format is implemented, the proprietary format and current process will be used for the retail pharmacy data submissions. MAA will not assign ICN numbers to these encounters and a complete resubmission will be expected if the data is rejected based on the current 2% error calculation. A Provider Crosswalk file was required to assist MAA to identify plan providers without Medicaid ID numbers. The pharmacy encounter data reports will continue to require valid Medicaid ID numbers to identify the Retail Pharmacy and the Prescribing Provider. Maintaining and submitting a Provider Crosswalk should not be necessary with submissions beginning in January 2005.
CHPW	Sample error file format including the ICN: - We received a sample_ert.doc in your email to plans on 4/9/04. The sample_ert.doc supplied only seems to include overview/summary information and not the detail including the ICN that is required. MAA's Q&A document referenced the sample_ert.doc as if it is the error file that we could upload. When could we expect that file format sample? This is critical for us to begin the programming work involved with this new requirement. After a rejected record is returned for reprocessing - Do we receive a new ICN if the same record errors out a second time?	MAA will be doing the User Acceptance Testing (UAT) with ACS starting 5/17/04 in preparation for encounter record submissions from the plans. During this UAT we will review the Encounter Transaction Record report and determine how the report will be designed and transmitted to the plans. The sample_ert.doc was not intended to be the final version of the report.

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CHPW	Has MAA identified any limit on the number of resubmissions of an encounter record?	No
CHPW	We understand from the all plan meeting on 3/16/04 that the 2% error threshold was going to go away and edits are to phased in over time. Does MAA have anymore information on how this will occur and when a new error threshold will be instituted?	After UAT is complete, MAA will be able to provide more information in it's instructions to the plans. A list of anticipated edits was sent to the plans on 4/9/04. MAA needs to complete UAT to verify that these edits will meet MAA's business needs.
CHPW	One of the issues we currently have difficulty with relates to claims submitted to us from labs. Per our earlier meeting with you, we are to be populating the performing provider field with the 'referring provider' element. We currently do not capture the "referred from" provider on these claims and thus experience errors on our current edit reports for not having a valid performing provider number. Is this still a requirement?	Yes - MAA in its billing information to Laboratories requires the claims to include a referring provider for payment. (Claims without this information are rejected). For Encounter Data reporting MAA will continue to require the "referring" provider Medicaid ID on all Lab claims.
CHPW	Loop 2010AA -When billing provider = pay to provider we are required to submit both a tax id and a Medicaid provider #, if known. How will this be scored? Currently we are able to submit one or the other, not both.	The plan will not be penalized if the Medicaid ID of the Billing or Pay-to Provider is not known to them, until such time that the National Provider Identification (NPI) is implemented. The ERT will "flag" invalid and incorrect Medicaid ID numbers for informational purposes.
CHPW	Loop 2010BA -When subscriber <> to patient in the case of a newborn claim when the mom is used for reporting purposes...how is the patient information to be completed? Do we use all mom info (i.e. name, address, etc.) with the baby's DOB? Often times the NAME of the baby is not known.	The subscriber will always be the patient. Use the Mom's information in the subscriber loop.
CHPW	What are the denial reason codes required for Loop 2300 NTE02?	This edit is being removed from MAA's edit process and the Loop/segment has been removed from the crosswalk.
CHPW	2310B Rendering Secondary ID, pg. 13 --You state that the Medicaid ID # is required, if known and that we will not be rejected if the number is not equal to	MAA will be editing the Medicaid ID numbers submitted against the provider master file.

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	the MAA provider file. Will there be some level of edit applied to this data element (i.e. type of provider needs to start with a '1', '8', or '9')?. If the answer is no edits are applied to this field, then I would be wondering why you would require this of the plans?	MAA will not reject the transaction if the ID number does not match the one on MAA's master provider file, however, these errors will be "flagged" for the plan's informational purposes. Once the data is entered in the DSS, MAA will analyze the "provider type" information and report the information found back to the plans.
CHPW	Both 837P and the 837I have segments that are required by the Implementation Guides in Loop 2300 CLM Segment but required the information is not maintained by the plans. What should we use to complete these segments?	Segments CLM06 – CLM09 have been added to the crosswalk with recommended Defaults. MAA does not use/store this information in the encounter data processing program.
CHPW	Pharmacy Format – How do you want us to remit the pharmacy encounter data file to you? Would this transferred through the current Valicert site as it is done today?	Yes – continue to submit retail pharmacy data in the current proprietary format through Valicert upload.
CHPW	Through our testing with ACS for the FQHC billing process via 837P, we learned that there are file size limitations for data transmission. CHPW requests that file size issue be researched with ACS to ensure that this transmission method will be feasible.	MAA has made note of this issue and is working towards a solution with ACS.
CHPW	MAA has not discussed a "dual process" or phase-in approach for this requirement change. This is not consistent with every other HIPAA related process that MAA has implemented. We understand the Encounter Data Report transmission is not mandated by HIPAA, however, as MAA is requiring a HIPAA transaction, we would appreciate a dual support process. This would take the pressure off of the plans to have to migrate to the new format all at one date in time.	MAA will establish a test Help Desk with a testing coordinator for implementing the ASC X12N 837 Encounter Data format. Based on the results during the test period, MAA will determine if a "dual-process" for reporting encounter data will be required after January 2005.
CHPW	MAA mentioned they are considering a monthly frequency for EDR, however, feedback to the health plans will not occur any earlier than on a quarterly frequency. CHPW would prefer to have monthly filing submissions made optional to the plans.	MAA will continue to require EDR submissions on a quarterly basis on the same schedule as it does currently. Part of the benefits of switching to the EDI electronic transmission of Encounter Data is that plans will receive immediate response to the

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		technical accuracy of their data. If the plan submits encounter data monthly then they will receive the Encounter Results Transaction (ERT) report monthly. MAA's EDU unit will also continue to do it's high-level analysis of the data on a quarterly basis.
CHPW	Is your expectation that the certification letter continue to submitted in the same way, specifically, soft copy sent over the Valicert site and hard copy with signature sent via mail to the address listed in the contract?	The specific instructions for submitting the certification letter will be included in the instruction guide. MAA will require the plans to send an email to notify MAA that all encounters for the quarter have been submitted and include: (1) a copy of the certification letter attached and (2) the date the original signed letter was mailed.
Kaiser	A problem for us on the institutional format is using the "Statement From & To date". Can Kaiser use the admit date and discharge date for these fields?	The Statement From & To dates can be different at times from the Admit-Discharge dates, but they can also be the same dates.
Kaiser	In the 837I Procedure Loop – Are dates required for HCPCS codes or only for the ICD9-CM codes?	The HI segment of Loop 2300 in the 837I transaction is used for BOTH inpatient AND outpatient services depending on the "Qualifier" code. ICD9-CM Procedure codes are only used for inpatient services. Since these procedures could be performed on different days during the inpatient stay this where 837I separates the dates of service for each procedure. Outpatient services always use the HCPCS and CPT procedure codes. The services dates are reported at the line level for each procedure in Loop 2400/DTP segment.
Kaiser	Field BHT03, Originator Application Transaction ID – I believe this field is a file key-area header field. The claim number is specific to the claim records. Are you saying that by loading the claim number at this level that you want a HDR01	We will delete this from the "crosswalk". We agree that this is not the place where "claim level" information is included.

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	record for each claim? You would then have the repeating headers, submitter and receiver record info records and subscriber and patient records for each and every individual claim. The way we were approaching it was to have one header, with a repeating key on all the records in the file with one submitter and receiver record for the submission and then repeating records the subscriber/patient/claim information as many times as there are claims in the extract.	
Kaiser	DSHS has always been interested in "run-out" (services provided in an earlier quarter that aren't posted until later in the year). Are you still going to want "run-out" and how far back should we extract it?	MAA is still very interested in "run-out". The plan is to change to the new format for services processed on and after July 1, 2004. Run-out for services processed on or before June 30, 2004 will be reported in the proprietary format.
Kaiser	Retroactive adjustments from prior quarters – are you going to need these?	Corrections to previously submitted and accepted encounter records maybe resubmitted as "replacement" records.
Kaiser	Will you be editing all required fields?	No – not all "required" fields in the 837 transactions will be edited by MAA during the Encounter Data Program process. All required fields in the 837 will be verified by EDIFACS and edited by ACS EDI-Gateway for format, not for content.
Regence	We need to know if there are any fields in the 837 "like" format that would not be included in a standard "true" 837 format. Would MAA accept a submission in a standard "true" 837 format that may provide additional fields and simply ignore the additional information provided?	MAA used the 837 Implementation Guide to develop the crosswalk. Additional information received but not needed in the Encounter Data program, will be ignored by MAA.
CUP	Prior to NCPDP Adoption, are pharmacy data submissions to be posted to Valicert or WaMedWeb? What about after NCPDP format adoption?	Until the implementation of the NCPDP format, pharmacy submissions will continue to be sent in the current proprietary format and submitted to MAA's Valicert SFT site. Submission of NCPDP formatted data will be determined at a later date in the implementation process.
Molina	Loop 2000B Segment PAT on the 837I: This segment is used to report Newborn	MAA only requires the newborn birth weight

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	Birth Weight when the patient's age is less 29 days old. If baby is admitted to hospital separate from the birth, do we still need to report the newborn birth weight, i.e. DOB=01/16/04 discharge from hospital = 01/18/04. New Admission date = 02/05/04 new discharge date = 02/25/04. The second admission currently does not include a birth weight. Newborn birth weight is only included on the newborn admissions only.	on newborn admission claims. This has been corrected in the crosswalk. The PAT07 -08 segments have been deleted. Newborn birth weights will be reported on newborn admission claims only in Loop 2300 HI Value Information segment.
Molina	What about paper claims? They are not in the 837 format. Will plans be penalized for these incomplete encounters?	Every effort was made to consider that only information that is required to "pay" a claim (based on MAA's Billing guidelines) is required in the encounter 837I and 837P transaction. The transaction must meet EDI specifications for the format, however as discussed at the 3/16/04 meeting the editing for content is done at MAA.
Molina	Even if MAA allows for run-out to be submitted on "old" format, would MAA reject run-out reported in the 837 format?	No – As long the "run-out" encounter data was not a duplicate. MAA will accept an "original" encounter in the new 837 format.
Molina	Monthly reporting is an extreme burden on the plans. Molina healthcare spends hours/weeks getting Quarterly submissions ready. MAA does not realize how much manual efforts go into getting the quarterly submissions good to go.	MAA understands the manual time and effort it takes plans to submit the current quarterly data in the proprietary format. This is the same reason MAA would like the process automated. The format is a standard format and needs to be developed only once. As with the "electronic billing" for services, once the report format is developed, it should provide for more accurate reporting and less manual intervention.
Molina	Why would we need to submit encounter data in two separate formats once the new format is adapted? The plans won't be doing anything new for claims processing so doing a new & old submission is not necessary and indeed a whole lot of extra work for the plans.	The 837 is not the standard format for pharmacy data. MAA has not developed the encounter record to report retail pharmacy data in the NCPDP 1.1 batch format yet. MAA has agreed to change the encounter data reporting from "service" date to "processed" date.

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Molina	Are you working with Milliman to ensure they can accurately combine the old encounter data with the new encounter data format for the 2005 risk adjustments? Is Milliman prepared to combine this data for up to a year?	MAA has agreed to implement the new format based on "processing" date. Claims processed by the plans during the period July – Sep 2004 will be reported in the new format in January 2005. The proprietary format will be used to report data due at MAA on July 1, and October 1, 2004 for claims that were processed by the prior to June 30, 2004. MAA will bear the responsibility for merging reporting requirement formats for a period of time and work with Milliman to develop the 2005 risk adjustments.
Molina	Loop 2300 Segment DTP02/03 – Molina does not store and to my knowledge cannot store the time of admission and discharge. If we cannot collect this data how will we meet this criteria? This is a New Requirement but not denoted as such.	These are required for the 837 transaction and can be "zero-filled" if not known. MAA does not edit this in the encounter data program.
Molina	Loop 2300 Segment DTP03 – Related to Hospitalization Admission date/discharge date. Do we currently provide this physician claim? Why do we need to find hospital admit/discharge dates for professional services provided while the member is inpatient? I don't believe this information is submitted on the provider claim.	This is a required field for the 837 transaction. The crosswalk has been updated to "zero-fill" if not known. MAA does not edit this in the encounter data program.
Molina	Loop 2300 CLM02 – Description says "sum of line item paid amounts in SV102". SV102 says line item charged amount not paid amount. Description does not agree with segment requirement.	The comment was removed from the crosswalk document to avoid confusion. The 837 transactions require "billed charges" in these segments.
Molina	Loop 2400 SV102 and Loop 2300 CLM02 – Looking for Line item charge amount and total claim charge amount. This is not **bolded** but is a new requirement. We are currently not required to submit billed charges for Professional services.	The crosswalk document has been corrected to reflect this as a new requirement.
Molina	Patient Weight loop 2000B Segment PAT 07 and PAT 08 – Note that patient weight is required if patient is less than 29 days old on the 837P. The newborn	The PAT07 and PAT08 segments will not be required in either the 837P or the 837I for

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	birth weight is submitted by the hospital on the initial newborn claim. Submitting the newborn birth weight on subsequent hospital admissions or professional claims is problematic and will cause additional hours of research for each submission by the plan.	newborns and have been removed from the crosswalk document. The Newborn birth weight for newborn admissions will be entered in "HI" Value Information segment.
Molina	Patient Information is required if the patient is a newborn (not required by the IG). In Molina's processing system, the patient and the subscriber are the same because we are a Medicaid line of business. MAA however requires patient information if we use the Mother's PIC in place of the Patient's (which happens most of the time on newborn claims). Molina's current outbound 837 programming template does not have this loop programmed. A significant amount of programming (approximately 80 hours) will be needed to imp0lement this loop. If MAA has a simpler alternative to get the same information, that would be very helpful.	The "Crosswalk" document now reflects that the subscriber will always be the patient for encounter data reporting. MAA does not use the dependent Loop in the 837 format.
Molina	The claim Note Text in loop 2300 NTE Segment replaces the proprietary Claim/Line Status code for denied claims. The deny status and denial reason is reported in this loop/segment. Once again, Molina's current outbound 837 programming template does not have this loop programmed. A significant amount of programming (approximately 50 hours) will be needed to implement this loop. In addition the claim Note field could significantly increase the size of the file for transmission (we see this as a potential issue).	This requirement has been removed from the crosswalk. MAA will assume all claims/encounters submitted by the plans are in a "PAID" status for encounter data processing.
Molina	Rendering Provider ID – Loop 2310B NM108 and NM109 – The IG requires the rendering provider's EIN or SSN if the rendering provider is NOT the billing/pay to provider. If the plan does not know the rendering provider's EIN or SSN is there a default value that will be accepted in this field?	Yes – default to "zero-fill" this field.
Molina	Inpatient Encounters – 837I ONLY – The Principal Procedure Information, Loop 2300, HI Segment is required by MAA for Home IV therapy claims (therapy after surgery). How do plans identify this scenario? Is there a specific procedure code? What if the code is not available?	According to the 837I Implementation Guide The principal procedure code is required: 1. On all inpatient claims when a procedure was performed. 2. On all Home IV therapy claims when surgery was performed during inpatient that resulted in initiating the therapy. The procedure code required is not the

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		"surgical code", it is the Home IV therapy service code.
UHC	2000C_HL Patient Hierarchical Level. Individuals are assigned their own recipient number for Medicaid. If this Hierarchical Parent ID number for a child's claim is not stored in our system will the State still require it?	No - MAA has deleted this Patient Loop from the crosswalk. Patient is always the subscriber.
UHC	Ambulance Transport, Spinal Manipulation, Conditions code indicators – Loop 2300 CR1, CR2, CRC – If this information is not stored in our system – will the state still require it?	No – These segments are situational and can gap-filled when information is not known.
UHC	Loop 2400 SV5 – Durable Medical Equipment – This loop/segment is required on the 837P. Is the state going to add these segments to the layout?	No – Loop 2400 SV5 is Required only when reporting DME claims/encounters. The crosswalk instructs the plans to follow the Implementation Guide for these fields when reporting DME information.
UHC	Loop 2400 CR5 – Home Oxygen therapy Information – 01; 02 segments are required on the 837P. Is the state going to add these segments to their layout?	No – Same reason as above. The crosswalk/layout instructs the plans to follow the Implementation Guide if this Loop/Segment is used.
UHC	Loop 2410 LIN – Drug Identification on the 837P: This information is not stored in our system for encounter reporting. Is the state requiring the health plan to pharmacy encounter separately?	This Loop is not being required by MAA for encounter data. Retail Pharmacy data information is reported separately to the state in the old proprietary format, until the NCPDP 1.1 Batch report format is implemented.
UHC	2000B_SBR Subscriber Information: SBR01 – Payer Responsibility Segment Code is a required field. Will the state be adding this segment to the layout?	Yes – This has been added.
UHC	2300 CLM – Claim Information: Segments CLM06, 08, and 09 are required on the 837. Will the state be adding these segments to the layout?	Yes – Included on the crosswalk.
UHC	2300 NTE Claim Note: Does the state require reporting of claims that were denied by the health plans?	Yes – The Encounter data reporting requirements include submission of all processed/adjudicated claims from the health plans. This Loop and Segment requirement has been deleted. All encounters submitted to MAA by the health plans will be considered to

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		be in a "Paid" status.
UHC	2300 CR6 Home Health Care Information on the 837I – The CR6/CRC Home Health information is not stored by the health plans, will the state still require it?	No – Home health information required by the Implementation Guide , but not stored by the plans should be "zero-filled".
GHC	Loop 1000A Segment NM108 (837P) NM109 (837I) Submitter ID – Who do we need to contact to get the plan submitter ID number?	Contact your Health Plan's IT or EDI department. All plans have been assigned a submitter ID number. For Group Health, contact Erlande Jordan.
GHC	Please define what are the "Hierarchical ID number" for Billing/Pay-to-Provider, Subscriber, patient etc, and how do we get that data/value.	Please refer the Implementation Guides for the definition/use of this terminology.
GHC	Loop 2000NB Segment HL02 Hierarchical Parent ID Number – Can we use our plan unique consumer number in this field?	No – Please refer to the Implementation Guide for definition and use of the HL segments.
GHC	Patient (Baby) weight – Will this field get edited and count as an error if the value is missing in the new format? We have difficulty with claims submitted to us from providers without the birth weight.	The Newborn birth weight is required when the 837I inpatient admission code = "4" (newborn). This will be edited by MAA and flagged for information if missing or invalid on the Encounter Results Transaction (ERT).
GHC	Loop 2300 Segment CLM02 the ASC X12N 837 Data content field indicates the value is "Total Claim Charge" but the comments state "Sum of line item paid amounts". Which number should we report? Does this replace the Line Billed Charges in the current proprietary format?	This has been corrected on the crosswalk. The 837 requires billed charges to be reported, both at the claim level (Loop 2300 – Total billed charges) and at the line level (Loop 2400 – Line Billed charges).
GHC	We find the current proprietary Encounter Data Guide particularly the "Physical Record Layout and Field Requirements" useful and easy to follow. Does MAA plan to produce one for the new data format?	No – The 837I and 837P have published Implementation Guides. They can be downloaded from the following website: http://www.wpc-edi.com/HealthCareFinal.asp MAA will publish a "Companion Guide" to supplement the IG based on the information in the crosswalks.